Practice Program under Quality, Safety, and Value for the last seven years, so I'm going to proceed with the presentation. I am not an expert in mental health services, which is why we have the expertise of Dr. Schnurr.

DR. SCHNURR: Well, that was a terrific introduction. I wish my mother had heard it. Just a little bit of extra background, the National Center for PTSD is a center of excellence in research, education, consultation, in the Department of Veterans Affairs. We are congressionally mandated, and we are celebrating our 29th birthday this month.

I want to say that Dr. McGuinn is one of our graduates. She trained with us, and I'm very proud of the impact that we've had on the system, and I'm also grateful for the opportunity to be here today.

My particular interest is in studying the treatment of PTSD, functional outcomes in PTSD, and especially designing

trials for non-pharmacologic interventions such as complementary and integrative health practices.

So Dr. Rodgers will give you an overview of the Evidence-based Practice Program, and then I'll talk about the PTSD guideline because I was one of the VA champions for that guideline.

DR. RODGERS: Thank you. I have to figure out the control. Thank you.

As we mentioned, I'm going to provide the overview for our Evidence-based Practice Program, speak about how we got our start and our partnership with Department of Defense, give you an overview of how the -- what our process is and development and the rigor that we undertake in the evidence reviews.

Since the focus of this commission is on mental health, we will also speak to our most recent updates related to mental health practice guidelines, and then some examples for

integrative health recommendations from the PTSD guideline.

The joint VA and Department of Defense clinical practice guideline program was stood up in 1998, and we've had a very meaningful partnership with DoD ever since then. The first clinical practice guidelines were actually developed in the VA in 1996, and it was a cardiology/congestive heart failure guideline, and it was so well received nationally that the VA decided that it would do more in terms of guidelines, and by 1998 had entered into a partnership with the Department of Defense.

Our goal with clinical practice guidelines is to improve the overall health of our beneficiaries by using evidence-based practices, and it has been shown since -- studies since -- in the 1990s that evidence-based practice does reduce variations in care and does optimize outcomes.

So our guidelines are specifically

designed to improve the overall quality of care and health management for both our Veterans health and military health care systems. We have a governing body known as the VA/DoD Evidence-based Practice Work Group that oversees the guideline development process and reports to the Health Executive Council.

As I mentioned, our governing body is the Evidence-based Practice Work Group. I'm going to put up a slide here that represents the work group members. But, you know, they're -- it's comprised of experts in their field from both the VA and the Department of Defense. On the VA side, they are appointed by the Under Secretary for Health, and on the DoD side of the house by the Assistant Secretary of Defense for Health Affairs.

I won't read the names that you can see there, but the types of offices that are represented kind of covers the gamut of what you would expect within health care.

So the governing body solicits and

prioritizes the guidelines to be developed as well as to be updated, and the guidelines are updated roughly every five years. And that's consistent with the Institute of Medicine's standards for trustworthy guidelines, which we do follow.

Our guidelines do have oversight and peer review process in place, and I'll go into more detail with that, and as I mentioned, we do report to the Health Executive Committee.

So to speak more to the actual development process, once a guideline has been identified either for new development or for update, we identify what we call champions and other professional organizations. We refer to them as chairs, guideline chairs, but we call them champions. But we have champions from both the VA and from the Department of Defense, and our interdisciplinary teams are fairly evenly distributed between VA and DoD.

Most of our guideline groups -- it varies, depending on the guideline and the

expertise needed, but usually it's around 20 people, 10 from -- we tried for 10 from each side, however that varies a little bit because we want to make sure that we get the correct disciplines represented on our guidelines.

All of our guidelines, as I said, are interdisciplinary. We always have primary care; we always have nursing; we always have pharmacy; we always have social work. And then the additional team members, it depends on what the guideline is. We often will have chaplains, chiropractors, we've had chiropractors on some of our guidelines. We've had acupuncturists on some of our guidelines. Of course, for mental health we have psychiatrists and psychologists, so we make sure that it's well represented.

We do follow very strict conflict of interest disclosure. Every member is asked to fill out a conflict of interest form at multiple times throughout the guideline process. And at many of our meetings, we do a

verbal acknowledgment of conflicts of interest as well. And we do not just go by what they tell us. We -- these are -- we do independent verifications for conflicts of interest on all of our work group members, and we require that our champions be -- have no conflicts of interest.

The work group itself, once it's formed, defines what the scope of the clinical practice guideline should be, and they develop the key questions. The key questions are very important because they define the parameters of the evidence review that will be undertaken for the evidence.

Simultaneously, we also conduct Veteran and patient focus groups to get their input into the guideline and what is important to them from a patient perspective, and -- because we want to include that to make sure that during the key question development phase, because again, like I said, that's what defines what we're looking for in the evidence. And so

we don't want to miss something that the Veterans feel are important. We want to make sure that that's included in the literature search.

Once we have a focus group, they stay involved in the process. They provide that input during the key question development process, but then later on when we get to the draft process, they are sent the draft for review and for input back to us. And primarily their focus is did we address the items that they had identified that were important to them.

We use a third-party independent -- actually use a contract company to do the guideline development itself, and they use a third-party independent for the evidence review. Currently, that's with ECRI. I don't know how familiar the commissioners are with ECRI, but it's a very large and well-known evidence review company. And actually they were one of -- I believe one of the first to be

identified by the Agency for Healthcare Research and Quality as a quality evidence review organization.

They've been around about 50 years and actually do a lot of work with Health and Human Services, CMS, NIH, so they've got a good reputation.

It takes several months to do the evidence review. They apply the U.S. Preventive Services Task Force criteria in looking at the quality of the studies for the review and give a rating to that.

Ultimately, the work group comes together in a face-to-face meeting for three and a half days where they then -- the work group members themselves review that evidence and then apply a second level of rating to the evidence in order to come up with -- ECRI determines the, we'll say, the quality of the studies, individual studies, and then the work group ends up rating the strength of the aggregate of the studies to come up with the

recommendations.

Obviously, it goes through several draft components before we have a final product. One of the things that we're proud of is that the VA/DoD guidelines, when they started back in 1998, included an algorithm in all of their guidelines, and that had not been done previously.

Now you see more and more of that happening, but that was sort of a first for the guideline community. And all of our providers' feedback that we get is that they really appreciate the algorithms. It makes it much easier for them to follow.

It goes through an iterative draft review process and drafts. Once it's ready, it goes out what we call internally. We send it out on both the VA side and the Department of Defense side to multiple providers. Actually on the VA side we send it out widely to basically all of our providers in our system. But it's -- that's done through the chain to

the VISNs and the medical directors and chiefs of staff to distribute out to their providers.

But we have a website that they can go to and provide feedback on the guideline. It's open for varying periods of time. Again, all of that feedback is addressed by the work group members, and any changes made to the recommendations are done so based, again, solely on the evidence.

We may get feedback that, oh, I always do it this way. But if the current evidence doesn't support doing it that way, we're going to say so. But all the feedback is addressed.

Once we have that cleaned up and ready, it then goes out again to the same people internally, but now we also send it externally to various professional organizations, individuals outside of our systems that are clearly recognized as experts in the field. And, again, they have that same opportunity to provide that feedback. And,

again, it is all addressed, and changes made are solely based -- have to be supported by the evidence.

Once the work group feels that they have a final product, then it is presented to the VA/DoD Evidence-Based Practice Work Group, that governing body for review, and it does get presented and hopefully approved. And I say hopefully because it is not an automatic. Oftentimes, the governing body work group will have additional comments that they feel need to be addressed. We've actually had instances where a guideline was not approved. So it's not an automatic.

And then in addition to the clinical practice guideline itself, we develop tools to help with the implementation. The guideline itself is usually 150, 180 pages. We'll come up with a clinician summary that's 30-some pages, a little more manageable, as well as a patient summary so that -- and it's written so that -- for the important components that the

patients value, and have told us this is what they need to know about whatever the disease is that they're dealing with. This is usually two, maybe four pages at the most. And then we also develop a pocket card for quick and easy reference.

This is just to let you know of our recent updates related to mental health. The Major Depressive Disorder guideline was updated and released in 2016, the Substance Use Disorder in 2015, and, most recently, the PTSD guideline in 2017.

Then the Patients at Risk for Suicide was originally published in 2013, and we currently have a work group in progress right now doing the update. In fact, they had their face-to-face where they looked at -- went over all the evidence just last week. So like I said, it's in progress. It's anticipated to be completed in January of 2019.

And I guess I should have, you know -- we do updates every five years unless the

evidence -- there's significant evidence to warrant an update sooner. Also, to do an update it takes us about 12 months from start to finish on an update, and for a brand-new guideline I'm going to say 18 to 24 months. It used to be 24 months, but we've gotten it down real close to 18 months now, and most of that time is consumed by the evidence reviews. And then related to mental health is our Opioid Therapy for Chronic Pain, which was just updated in 2017.

And now I'm going to turn it over to Dr. Schnurr.

DR. SCHNURR: Thank you, Eric. So as I mentioned earlier, I was one of the co-champions for the PTSD guideline. I'm also a member of the Evidence-Based Practice Work Group, so it's given me additional insight into the process.

The PTSD guideline was revised from a prior format in which consensus was used along with evidence. It has become a best

practice around the world in the development of guidelines to base guidelines on evidence, and when there isn't evidence to say that there isn't evidence one way or another.

So the PTSD guideline had to get pruned, essentially, from over 200 -- I think 220-some recommendations, we came down to 40 evidence-based recommendations. This is actually better for all the stakeholders because Vets get better information about the evidence, providers get better information about the evidence, and it's a lot easier to use the guidelines. It's also a lot easier to defend the recommendations because it's based on evidence review and not the opinion of a bunch of people in a room.

So because of the commission's focus on complementary and integrative health, I just wanted to mention a few things that are particular to the guideline. I'm glad to take questions about broader details.

The first bullet that's listed here

is about treatments that are not necessarily complementary, but they're different, such as repetitive transcranial magnetic stimulation. That's actually an FDA-approved treatment for treatment-resistant depression.

ECT, again, an approved treatment; hyperbaric oxygen therapy, which is actually quite a controversial treatment; stellate ganglion block, likewise, and vagal nerve stimulation. The evidence for treating PTSD for all of these is insufficient right now.

Also the evidence is insufficient for acupuncture. There's been some work, but the body of evidence is quite small, and the quality of the evidence is not sufficient to make a recommendation yes or no.

And by the way, Eric didn't say this, but the way the guidelines grade evidence is to make a strong recommendation, a recommend, or a weaker recommendation, a suggest, and you can recommend for or against, or suggest for or against. In the PTSD

guideline, because we were aware that there were many treatments that have advocates of people who are using the treatments, we used insufficient evidence ratings for those kind of treatments to ensure that users would know that we don't know one way or the other.

So going on and looking at the complementary and integrative health practices, we found the evidence was also insufficient for meditation, including mindfulness, which happens to be the most widely practiced type of meditation for PTSD in VA. Yoga and mantra meditation -- there's a new study published on mantra that was favorable, and so it's possible in the next guideline that we would see that evidence differently.

So, Eric, do you want me to sum it up?

So the practice guidelines are a foundational component of our evidence-based practice program. What we've tried to provide here is a sense of the process and the rigor.

I think we really do stand on an international footing in terms of the quality of our guidelines.

Our recent diabetes guideline was rated in a JAMA article as one of the top guidelines. There's some controversy about the guidelines for managing diabetes, and the VA/DoD guideline has been receiving very good press. That's produced by the same process as the other guidelines.

The hope of the guidelines is that evidence -- that mental health treatment is improved by using evidence-based practices and reducing unwarranted variation in care, as well as optimizing patient-centered outcomes. So guidelines are not mandates. It's important to understand that these are not thou shalt kind of recommendations.

But they are suggestions for how to practice. The guidelines all heavily emphasize the importance of taking patient preferences and values into account, considering resources

and other factors that tailor the care to the individual within the body of evidence.

And so we suggest that you may want to review the recent CPG recommendations on PTSD and depression and other mental health disorders to inform the commission's work.

Thank you, and now I guess we'll take questions.

CHAIR LEINENKUGEL: Thank you so much, doctors. That was an excellent overview and gives us a lot of follow up.

I've got a couple of pages, so I don't want to be the lead on this because it's going to lead into, I think, directionally where we need to go as the COVER Commission.

DR. BEEMAN: Doctors, just two quick questions. Are there any complementary treatments that have met the rigorous criteria of the clinical practice guidelines?

DR. SCHNURR: Not in any PTSD guideline that exists. I'm not aware of whether there are any for other mental health

conditions, but for -- that are prevalent in Veterans, but the UK guidelines, the Australian guidelines, the American Psychological Association, and the VA guidelines, none of them have found the evidence sufficient yet.

Can I just say it's also challenging, and much of this work is not as rigorous as it needs to be because it's hard to study something for which you essentially can't have a placebo.

Drugs are easier to study. They have their own challenges. This happens to be a particular passion of mine. I love the challenge of trying to figure this out, but the problem is that often this work is threatened by the possibility that placebo effects can account for the findings.

And so there are really good people in the field now, with much more rigorous studies ongoing, but to the best of my knowledge -- and I'm speaking now as a scientist, not a representative for VA -- the

evidence just isn't there yet.

DR. BEEMAN: Sure. I had one other question: Nowhere yet have we mentioned the fact that mental illness impacts families as well, so it's not just the warrior who has the mental health issue, it's the family. Is family therapy any part of the guideline of treatments for PTSD that you've seen?

DR. SCHNURR: We do have a recommendation around couples therapy. We recognize the importance of this, because PTSD affects everyone in the life of a person who has PTSD. But the evidence is also insufficient for couples therapy or family therapy at this time.

DR. RODGERS: And I would just like to clarify, it's not related to therapy, but when we do the focus groups, we do include family members as well. So we do take that into consideration.

DR. BEEMAN: Just to comment for Jack: What I had wanted to get on record

earlier is that I think, because mental illness impacts not just the warrior but the families and by extension, the community, I think it's really important as we talk about our findings over time, that we don't discount the import of family.

I think, Dr. Schnurr, your answer that it doesn't have evidence yet. We anecdotally know that including the family, that this helps the family. There are certain things about complementary medicine that may not be able to be scientifically proven, but may have anecdotal evidence that helps us. Otherwise, it's going to be hard for us to talk about any complementary medicine if it can't be proven. Thank you.

DR. SCHNURR: May I comment, because I actually believe that we can prove a lot. Even for the challenging complementary treatments that the commission is studying, it just hasn't been done to a great extent yet.

There's just excellent ongoing work

that I think will be much more definitive in the coming years. I actually don't believe it's -- it's challenging to study, but it's not impossible to study, and we will have much better evidence.

MR. ROSE: Thank you. To whoever would like to answer this: As far as a mental health advocate, the mental illness is very difficult, one, to diagnose. So you're dealing with one here with PTSD, and there's not enough evidence base to qualify some of these complementary treatments.

Is there any way you can try to fast-track some of these? They have proven -- I don't know, maybe it's anecdotally, but some of this stuff really works.

If you've got every five years that you're looking at this, and it takes about a year to do it -- I know it's a huge process that you have to go through. But this is really critical for mental health, and that's the purpose, that's why we're here.

I don't know. I don't know if you have any comment on that. Thank you.

DR. SCHNURR: I think I would say that I'm not the right person to answer a question about fast-tracking. That would be a question that would fall more into the VA or DoD research spheres. But I can say to the best that I know, there's a lot activity going on now, and the next few years should have, as I was saying before, much more definitive information.

DR. JONAS: Thank you very much for that great overview and the system you've built, which I think is fabulous. I've seen it from the inside and the outside, and I think you've applied the National Academy of Medicine's principles for guidelines even better than they have, in my opinion, so it's really great.

Just a couple of questions, I know, having been involved in this process for a while, so I know -- is there any training,

especially for the patient input? The fact that you have the patient input on multiple levels is fabulous, but the dynamic, as you know, in many of these groups can be quite touchy. There's a power dynamic, there's an expertise dynamic, there's a personality dynamic, if some people dominate.

Any work on trying to create a process that sort of enhances the patient input a little bit better to balance those issues?

DR. RODGERS: Good question, thank you. Yes and no, is the answer. Yes, we have thought about that. At the moment, we haven't figured out a way to actually make that work, from multiple standpoints. One is that in order to do that, you kind of have to maintain a cadre of patients, and that becomes quite expensive.

Then the other is that under current law, we would have to have no way to cover their reimbursement for traveling to conduct some of the work that we do.

The way that we've addressed this is that we go to them for our focus groups, and while it's not extensive, we do some preliminary kind of education with them in terms of laying out the expectations and the ground work.

We explain to them what a clinical practice guideline is and what it isn't before we start, and we do have interview guides that we follow to get at the important points from a scientific standpoint, but at the same time obtaining their perspectives in what they value as important.

I didn't go into great detail, but that second phase is called a grade methodology process, and significantly incorporated is both the patient preference and the provider preference. Those have significant value, and they are weighted within the grading of the system for the evidence.

So those can help to either raise the level of a rating or actually lower the

level of a rating. That's why it's a yes and a no that we've addressed it.

DR. JONAS: Thank you very much, and I encourage you to keep working on that. It's a great challenge. I think the grade is a great advance in what used to be done in these areas, which is just like, Well, if it's not at the top of the hierarchy in a random, double-blind, placebo, multi-center, clinical trial, then it's insufficient, and that still tends to be the approach.

The levels of sufficient, insufficient -- I'm glad that you're putting things into sort of insufficient evidence, even though one could say, gee, hyperbaric oxygen, for example, in my opinion, there's plenty of evidence that shows that it does not work, so you put it in the insufficient evidence.

But there is this sort of tension between the effectiveness and efficacy of research, efficacy usually being counted as more rigorous, because they look at randomized

control trials, theoretical components of a placebo, etc., to try to determine an effectiveness, which don't work out there in a more heterogenous environment in populations.

So working on coming up with models that can incorporate those assessments, I think, is important, especially when we now know that two-thirds of what has been proven in top randomized control trials can't be replicated, even when it's published in top journals in those areas.

I'm wondering if you've applied this approach to -- what we've been charged with here is to look at models of care. It's so much of what is provided in these guidelines are individual treatments, because it's easy to do the research on that.

So we end up with these laundry lists of, this works, that doesn't work, etc., when in real life, what I do in my practice and what most clinicians and patients do is, they go through a whole process of treatment in

setting guidelines, and that's how process guidelines are often set up. But we're not sure if those will actually work, if those models work, and I know it's a challenge to do that.

Have you thought of maybe coming up with some creative ways to evaluate models of care and visualizing all of the treatments on sort of a similar map to allow decision-making within practice, looking at evidence-based grounding?

DR. SCHNURR: I think that one's for me. The short answer is yes, we have thought of this, but the work in PTSD has focused primarily on collaborative care in primary care settings. So integrating mental health care into the primary care setting, creating step-care models where lower-intensity care is delivered in primary care if a patient is not too severe, and then moving the patient along the continuum -- that evidence is still mixed. In fact, I did the first randomized trial of

collaborative care for PTSD, and we found it changed the care, but it didn't improve outcomes.

A study that was done in the DoD found more modest improvements in outcomes, and I think the challenge we're seeing by studying models of care is that the effectiveness of the models depends on the care that's provided within that model. Right now the most effective treatments we have in our toolbox for treating PTSD are selected psychotherapies.

There's a number of them, patients have a choice of things that they we do. Essentially, psychotherapies that focus on processing the traumatic event in some way seem to be the most effective. So a model of care that ultimately doesn't lead to that as an option is less likely to have a large effect.

In fact, the guideline recommends these trauma-focused psychotherapies as the first line of treatment over medication and other types of psychotherapies, some of which

are also suggested.

DR. JONAS: Thank you. Just one more question, if you will, so surgery is used in interventional studies, injections, surgery, a lot of things were used a lot for chronic pain. Is there sufficient evidence to show that those actually work or reduce pain chronically, or are useful in mitigating the opioid issues, using the criteria that you approach? Has a guideline or evaluation been done on interventional studies like that, that are a key part of chronic pain management?

DR. SCHNURR: I think that is something I can't comment on, given my expertise. I don't know your process for finding parking lot questions, but that would go beyond my knowledge.

DR. JONAS: It's opioids also, so it often comes into opioid management. It's a non-pharmacological approach. I didn't see it on the list. I'm just wondering.

DR. RODGERS: I do know that when

the opioid guideline was updated, that was among the key questions that was looked at. I apologize. Off the top of my head, I can't necessarily tell you exactly what the ultimate recommendations were that ended up in the guideline, but I do know I remember it being part of the key question development. I can get that answer for you.

DR. MURPHY: One of the examples we took at were interventions for low back pain.

DR. RODGERS: What she was saying, if you didn't hear her, our low back pain guideline did include that in interventional and looked at complementary medicine treatments as well. So I'd just have to look at the guideline to let you know.

DR. JONAS: I don't think they included surgery in that. I would consider it a non-pharmacological approach, and just wondered where it fits into your evaluation approach for these areas.

DR. RODGERS: I do know we had an

interventional surgeon that was one of the champions.

DR. JONAS: And I wondered, was there a CAM person on the surgery one? A non-pharm person? There must have been.

Just one final question is the application of the guidelines -- so often, it's difficult to get the application of the guidelines. Clinicians don't necessarily use them, patients don't sometimes understand them or care about them, and the appropriateness of applying them is another whole discipline, and I'm just wondering if that's something that you've looked at in the VA, in terms of the appropriateness of the use of the guidelines. Are they out there being used? Are they benefitting people if they are used? Is there any evaluation of that?

DR. RODGERS: Currently the only way that we have to evaluate that is what I can call indirect measures. We keep striving for that. Electronic health records, where they

are implemented, make it easier to track and monitor and be able to assess the direct outcomes on them.

Right now they look at indirect measures. Pharmacy is a good example where, every guideline that comes out and we're recommendation alternative therapies instead, then we should be seeing a decrease in the use of whatever that particular medication might be.

Our hyperlipidemia guideline is a good example of that. We still recommend the use of statins, but the practice at the time was that everyone was going on high-dose statins, yet the evidence showed that you received no better benefit at high doses than you did at a moderate dose.

So when that guideline came out, we saw a significant decrease in the high dose ranges of our statin usage and the coinciding money saved. That was quite significant. So that's an example.

But we're always looking and talking about how else we can get this in front of the provider where it's used. So besides our publication of these, we've tried to be creative, and we've turned to partnering with Epocrates, who is now placing our guidelines on their mobile app platform, which we know a lot of clinicians utilize. It's right in their pocket. We're strongly advertising that with our providers, that that's another place they can go to get it rather than try to pull it off the computer or get a hard copy of it.

We also know that our providers look at these other journals, so the Annals of Internal Medicine has committed that they want to publish all of our guidelines, and so every time we do a guideline update, it gets published in the Annals. That way we know our providers, both on the VA and DoD side will look at that, possibly before they'll look at something that comes out from us. So we try to be creative in getting it out there in front of

people.

We also have a study that's about to kick off a survey, again, trying to get at that answer, asking the providers, are they using them? How are they using them? What do they want from us that would improve their utilization of it? Hopefully, that will come out in the next couple of months.

DR. JONAS: I just want to commend you on this work. This is the heart and soul of determining what works and what doesn't work, which is what we all want to make decisions about. So you're doing fabulous work. Keep it up, and I just want to make sure the commission realizes that this is a thing that we should clearly focus on in terms of that. So thank you very much for your efforts.

CHAIR LEINENKUGEL: There's no question that you bring a lot to the excitement of the commissioners at this point, and this is going to continue for the next 18 months. It's a good opportunity to be on record as Tom

started, and Wayne, and Jack at this point.

So I want to go on record with two things: number one, what Tom stated, I'm more in that camp. I think we're moving too slow. This commission was put together and was asked to be part of a law two years ago, and it took us two years to get to this portion. That's way too slow, because we are losing 20 Veterans a day.

And to what Jack said, I firmly believe, because I've dealt with two families now that have had Veterans commit suicide. It impacts the family, and in many cases, the community, especially if it's a small community.

That being said, we have a sense of urgency as commissioners to come up with recommendations, and I will tell you that I love the procedures. You have a very disciplined approach. There has to be that, but there also has to be a sense of urgency to some of the things that you stated, and I don't

think there is, and that's my opinion.

Whether they're complementary, whether we think they work or not, there's a group of Veterans and a group of advocates that believe they do, and I'll give you two instances.

HBOT: There are two large groups in the United States right now trying to prove that it does help, even if it is a select group of Veterans. I have heard their stories, I've seen them in person. We will bring those up in front of the commissioners. Does it work on a whole? I don't know. I don't know anything about except what they told me. There's different levels of pressure, there's different variations to the treatment, so there is no what you're trying to do here, set guidelines and standards.

If there is a piece of evidence that maybe at a 2.2 pressure over a 40-minute period sustained over seven weeks, there's an 80 percent improvement. I don't think they've

gotten there yet, but there's that possibility.

Another group -- let's face it -- is medical cannabis, not recreational, but medical. I think we're doing an injustice, I think that our largest VSOs have stated through their membership that over 90 percent of American Legion, which is two million strong, Veterans are advocating that we at least take a look at research within the VA, which I don't think we're doing. To me, that makes no sense. It's a plant, it's an herb. I'm not advocating for recreational use at all.

But from this commission, we need to look at every variation of complementary type of care under what we had yesterday, whole health. I know I'm editorializing a little bit, but I want to at least get it on the public record that these are things that I think we need to start taking a look at, along with -- what are a couple of the other ones? I know, Paula, you talked about ECT and repetitive transcranial magnetic stimulation

that had some other groups that said that was really helping me.

So when I look at it in the context, I look at it as a toolbox and a toolkit. Are we going to at least give the opportunity for Veterans, in our subset of what COVER Commission is, to have an expanded toolbox to do evidence-based studies, to see if it does work, rather than doing incremental one-offs, whether it's done by the Army in conjunction with a broader DoD, and maybe VA being brought in at some point?

I think that you need to, since you're on this guidelines approach, to maybe be some advocates, or maybe it needs to come from the top, from the Secretary of the VA and the Secretary of DoD to make some of these statements. We'll take that as a next step from out group as well.

My last point is, from an evidence-based practice, and I would think both of you have had these occurrences or situations, just

give us a sense for how Veterans are being treated today. Let me give you two scenarios, because they're both true; they are scenarios that I am aware of.

A woman Veteran, after two years, discloses that she's had major ongoing sexual trauma during her four-year enlistment. She is now homeless. She has a child, and she has nowhere to go. A VA person actually approached her during a homeless stand down. How, under your guidelines, would she be treated today, once she came into the VA?

DR. SCHNURR: Well, if she were receiving guideline-concordant care, she would have a comprehensive evaluation that would go beyond just the diagnosis of PTSD, but that would look at the whole person, her social circumstances, and help determine the hierarchy of needs that she has.

With guideline-concordant care, there would be shared decision-making, some collaboration between the patient and the

provider or providers that are involved to help determine the best course of action for her.

We would be recommending, as I mentioned, if PTSD is the primary thing to treat at that time, we'd be recommending, according to the guideline, some kind of trauma-focused psychotherapy. If that's not what she wanted, we -- sorry?

CHAIR LEINENKUGEL: If you would, please, just describe psychotherapy and a psychotherapy session. I have no idea what that means.

DR. SCHNURR: Okay. So I'm also, for the record, not a clinician. I was trained as an experimental psychologist. But I've been hanging around with very smart clinicians, and I'll look to Shira to correct me with anything that I say.

But in psychotherapy, I mentioned the word collaboration. Essentially what you've got is a patient and a therapist talking about the issues that are relevant to the

patient. Now, in good psychotherapy, no matter what kind it is, there's exploration at the outset to understand the person and their context and clarify what they want to get out of the therapy.

In the most effective therapies, people typically would learn skills and tools for understanding their thoughts and their feelings. To me psychotherapy is one of the most natural treatments around, because all you're doing is helping a person learn some skills to heal themselves.

So in the case of PTSD, I think what we're doing is treating a person who is stuck, whose natural recovery has failed and helping that person get back on their feet. The different theoretical approaches ultimately come down to enabling the person to change how they think and feel.

There may be exercises; there may be what is called homework, even, in some therapies to go out and do some activities.

Some therapies are just about the talking. But essentially what you're doing through this process is helping the person get back on track.

Now, that's my non-clinician view of what psychotherapy is, and Shira, if you want to add anything to I've said, I welcome that.

DR. MAGUEN: And I'm also very happy to work with the commissioners to do a presentation on the different types of evidence-based therapies in a very concise way, if we decide that's what we want to do.

I agree; in particular, when someone is homeless, we would really focus on the primary needs first, to really make sure that the person is in a stable environment. Sometimes it's very hard for people who are moving from place to place or don't have a stable base to do the kind of work that is needed for recovery.

So I think that really laying that groundwork first and working on some basic

skills that can help the person just cope with the day-to-day stresses is really important in a case like that.

From there I think that some trauma-processing work can happen over time. But I think, in terms of the nitty-gritty, again, I can go over that with the commissioners later about what those therapies would be.

CHAIR LEINENKUGEL: Let me provide the outcome. This individual lives in Phoenix, Arizona, and this lady went from being homeless with a child on the streets, had no family to turn to, because she did not want to actually bring it to the attention of her family or friends.

It was a VA nurse, during a homeless stand down, who found her and took her in. She went through psychotherapy, went through what I call a partnership and collaboration with the Arizona Coalition, who the VA nurse also brought in. They are very close to the Phoenix VA.

So it was a collaborative effort in getting her re-established for bringing her self-esteem back to where it needed to be, and right now she's part of the Arizona Coalition, working with the Phoenix VA, and it's one of those success stories.

Let me bring up number two now, and then I'll be finished. A male Veteran who comes in finally discloses that he has not slept well for the last 18 months. He has night sweats, tremors, temper. He has lost his family, and is by himself, because his friends can't stand being with him, and he can't relate to family and friends. He walks into a northern Wisconsin VA. How is that person -- I think I can ask you, Shira. How are they handled in a situation like that, using our evidence-based practices?

DR. MAGUEN: This individual just feels disconnected; that sounds like that's a key issue that they're presenting with, this disconnection from many sources, feeling really

alone and isolated. Is that right, just to clarify?

CHAIR LEINENKUGEL: Yes, and also he could not get out of the trauma that he witnessed in combat.

DR. MAGUEN: I think, in addition to our evidence-based treatments, psychotherapies in particular, cognitive processing therapy, prolonged exposure therapy, I think that what we now have in our VA system is peers who can really assist with that isolation.

I think for a lot of people who come in with that perspective, really feeling disconnected, feeling hopeless, feeling like they are really struggling with even wanting to move forward in a lot of cases -- we've talked about suicide here, as well. I think that the key is that we use a multimodal approach with a person like this.

So it's not only about getting them into psychotherapy, but this person might not even be ready or willing to engage in that kind

of care. So I think that using the resources that we have available, using the peer support network, I've seen incredible work done with motivational interviewing or the motivation to engage in care, so to speak, where peers can come in and say, Look, I have gone through this. I know what you're going through, and here's what helped me. Lets' talk through this.

I think that's something that we really want to leverage with those types of Veterans. Again, when we're talking about and thinking about systems of care, we have to use all of the resources available.

I've also seen incredible work done with -- if we think about the whole-health model, spiritual leaders too, which we have available to us at the VA. For some people, that loss of faith, depending on what that person saw in combat, we want to leverage those resources too. So having the person be able to think about how their spiritual outlook

fit into this, and connecting them not only with one mode, but connecting them with our system of multimodal care to get the person engaged and ready move forward with any care.

CHAIR LEINENKUGEL: I did this exercise for a reason. What a great response, and I think what you just described is the new type of care. This happened in 2010, eight years ago, and the person was given two different doses of drugs to include an opioid, because he did have pain, and a benzo to help anxiety and sleep.

So he became a wreck, and so he disconnected from the VA, and was found by the local police, and actually went into treatment. But you have to remember, this was eight years ago.

What has helped this individual turn off all of his drugs was medical cannabinoid oils. So that actually flipped the switch for him in his case, because he probably never had the opportunity to receive the type of

evidence-based care, and what I would call a little bit of integrated holistic care at the same time, and peer counseling, which we talked about yesterday.

So I sort of tricked it up here just to get a response, to let you know that I think the VA has come a long way in eight years. That's number one; that's the news flash.

But there are people still out there from a consistency basis, and you talk about guidelines that we may be missing, that aren't getting the same consistent type of approach on a medical-based, evidence-care background.

So I bring that up only for consideration from commissioners and experiencing this in the last 18 months again, my time within the VA, and some of the anecdotal stories that I pull from that; those were sort of the a-ha moments of how we need to do things differently, quicker, faster.

We have to have a sense of urgency. To do guidelines and evidence-based takes time.

So I think as commissioners, we need to ask ourselves, are we willing, 18 months from now or even before, to make some bold recommendations prior, to move things along, faster, or evidence-based trials, testing, for our Veterans' toolbox?

So I just wanted to give you my sense of where I'm at, and Jack, you probably want to add something.

MR. ROSE: Thank you, sir. One thing: Everybody in this room is different. Each Veteran is different, so I think the approach -- and maybe it's not all going to be evidence-based -- but you have a basic starting point.

And then as the individual comes in, will it be possible to provide that individual with something that works? What works for Matt may not work for Wayne. They're both Veterans, they've both got PTSD, and I think we can all agree, when you're talking about mental illness, behavioral health, it's not an easy

thing to diagnose.

I'm not a clinician, I'm not a therapist or a psychologist, but just as a family member, it's very difficult. So if we can have our folks who are in the field who are treating the follow who is coming or the woman who is coming in with a few more things to be able to help her out, I think that goes a long way. I don't know how it can fit into the system, but I believe it works.

DR. RODGERS: Thank you, and we totally agree with that, and that's why our guidelines say that that's what they are; they're guidelines. As Dr. Schnurr eloquently said earlier, they are not Thou Shall.

We recognize that every patient, every Veteran is an individual. Every provider is an individual, and their expertise and treatments that they might offer vary from provider to provider, as well. So they are guides to follow that are based on the evidence. The evidence says that this is the

best available treatment; however, we allow for that flexibility for the individual.

We recognize that the best treatment for them may not work at all, and that you may have to do something different, and the guidelines allow for that flexibility so that we don't come along and say you're a bad person because you didn't do the letter of the guideline. It was never intended to be the letter.

DR. SCHNURR: If I could just emphasize that the best guidelines clearly indicate that one size does not fit all, and that the individual patient with mental health disorder, physical disorder, needs to be evaluated.

I can say, at least for the PTSD work group, we talked a lot about this, and we tried to write it into the guideline's DNA so that people would understand the importance of, on the one hand, understanding the best evidence and the recommendations, along with

ensuring that the individual's needs, preferences, and such, were respected.

DR. JONAS: I think in the spirit of urgency and the fact that we have a system that is very rigid and structured, appropriately so -- developed over many, many years because of problems that have occurred by not applying evidence-based practice or not applying research -- that maybe a new paradigm and even how we do evidence to delivery needs to be accelerated, such as evidence-informed patient-centered care that maybe is defined a little differently than evidence-based guidelines in those areas.

I urge the VA to see if they can't accelerate the application of the kind of person-centered care we've talked about, because I daresay spiritual care and cannabis oil probably isn't in the guidelines, but it helped these people. So how do we do that without abandoning evidence?

CHAIR LEINENKUGEL: Dr. Schnurr and

Dr. Rodgers, thank you so much. You're probably going to hear back from us. We're going to corner you, just like we are the other presenters from yesterday, whether it was Dr. Stone, Dr. Clancy, Dr. Meyer; we need you to be actively involved along with this commission.

We look at this as a partnership for Veterans and for the VA going forward, so we're all in this together. It's not adversarial; you're providing the knowledge-based, what's happening today, and your future outlook as well. So thank you so much for taking the time to be with us today.

DR. SCHNURR: And I'll say thank you. We're very glad to assist the commission.

(Applause.)

CHAIR LEINENKUGEL: Commissioners, we have a 15-minute break, so please use it, and I'll see you back in 14 minutes.

(Whereupon, the above-entitled matter went off the record at 9:34 a.m. and resumed at 9:57 a.m.)

CHAIR LEINENKUGEL: I'm going to add one admin item at this point in time. I will be leaving to head downstairs to get the Acting Secretary, Peter O'Rourke, probably in the next 35 minutes.

Security will give me a call. So, during Fran's presentation, when you see me leave, I'll be right back with the Acting Secretary.

But at this time we have Frances Murphy, Dr. Frances Murphy. Who was in the background yesterday, because she has a significant role as far as support as well.

But she also has had a distinguished career and terrific background. So, if I may, let me read a little bit about Dr. Frances Murphy.

No need? Well, you're going to get it. You've had a distinguished career, Fran, as a health care executive, Board Certified Neurologist, and a United States Air Force Veteran.

Dr. Murphy currently services as President and CEO of Sigma Health Consulting, a woman Veteran owned small business. Congratulations.

Dr. Murphy is a senior health care executive with extensive experience in managing, operating, and transforming large programs in health care organizations.

Her experience is diverse. And covers the wide range of activities encompassed by the federal health care market.

This experience results in a unique ability to understand the global picture while being expert and knowledgeable about technical and scientific methodology in a rapidly evolving environment, which we're certainly in.

Dr. Murphy's current work has been focused on evidence-based medicine, patient-centered care, and mental health policy and program evaluations. She published numerous peer reviewed publications, book chapters, and reports.

And has had over a 20-year career working in the Department of Veteran Affairs at VA Medical Centers during neurological care, research, and education, as well as in the VA Central Office as a senior executive.

Welcome Dr. Fran Murphy. Fran?

DR. MURPHY: Well, thank you. Okay. I'm technologically challenged on a good day. So, having red to me means it's off.

But, anyway, so thank you very much. I'm delighted that Sigma was chosen as the Veteran owned small business to support your activities.

And we have a great staff who you've met this week. This presentation is going to be a little bit different then some of the ones you've had so far.

Because it's really focusing on what your charge is. And how we can begin to move towards getting you the information that you're going to use to make your decisions and recommendations.

I thank Dr. Rodgers and Dr. Schnurr for providing the great background in the evidence-based practice programs. Because I think that is at least a good model to get you the kinds of information that you can use.

And to begin deciding what the evidence is that complementary and integrative health treatments are effective.

So, with that, the aims of this session are to really review the part of your charge that is related to conducting an evidence-based review. To describe the proposed time line and the process for doing an evidence-based review for you.

And to tee up a couple of decisions that we need to make sooner rather than later. You've got an 18-month period to complete your charge.

And in order to get there, we're going to have to begin relatively quickly in addressing some of the issues.

So, I'd like to discuss with you the

potential scope for your evidence-based review. Some proposed key questions.

And hopefully, get your endorsement of some of those issues. So that we can move forward and begin the work.

So, this is -- okay. This is part of the charge. But, I thought we had swapped out this slide.

So, you are charged to examine the available research on complementary and integrated health treatments for mental health. And identify the potential benefits and including this list of therapies in treatment for Veterans who have mental health diagnosis.

So let's talk about how we can potentially address that issue. So, what is a proposed approach to conducting an evidence-based review to make that charge?

And I'd like to answer a couple of questions for you. Why, what, when and how?

So, why? Well, your charge is to examine evidence-based treatment models used by

VA for treating mental health conditions of Veterans.

And then to make decisions about what the potential benefits are of including complementary and integrative health treatments.

We've heard from the evidence-based practice folks that they do those analysis about evidence-based practice. And they've included some key questions about complementary and integrative health.

But many of the guidelines, the evidence reviews are several years old. And so they need to be updated.

We heard yesterday from the Office of Patient Centered Care. And they gave a very inspiring presentation about their passion for whole health and VA's implementation of that.

What was missing, in my view, is the fact that so far, neither the state of the art conference or the evidence reviews have really looked at the specific issue of mental health

conditions.

And what the effectiveness is of the complementary and integrative health interventions in addressing whether mental health outcomes and patient centered outcomes for those individuals, are improved.

And that's really your charge. So, what are we going to do?

Well, we're going to do an evidence-based review for you. And the what is, an evidence-based review is a process that allows you to systematically look at the research, which you are tasked to do by the legislation.

And to make sure that you're gathering all of the relevant information. We're not going to cherry-pick certain studies.

We're going to have an objective systematic process that minimizes the impact of any bias or errors. And to allow us to give you the information about what the evidence is, so that you can make relevant decisions.

The decisions are yours. Your

support staff are going to gather the evidence for you.

So, what about the question of when? Well, let's look at a potential time line. The star on this -- this Gantt chart or time line, is where we are now.

We've been working for several months with the VA staff in trying to structure this meeting. And to help make some early progress on issues like the evidence-based review and the survey, which we'll talk about next.

And in order to complete the evidence-based review or the system map review for you to be able to make decisions, we need to begin relatively quickly.

And that's why I'd like to get your endorsement for the scope of the review. And the key questions, if possible, sooner rather than later. Today, if that is possible.

So, what's the process for the evidence-based review? These are the steps

that were on that time line.

As you heard from Dr. Rodgers and Dr. Schnurr, defining the scope of what you're going to look at is the first step. Then you develop key questions.

And the key questions are designed to make sure that we have a common understanding of what your priorities are. And what kind of research you want us to gather.

And the key questions really give us the opportunity to objectively and clearly define all of the different aspects of a search for the literature.

We'll then begin to review the studies that come back from that search. Including an abstract screening, a full tech screening, and then do a report on the evidence for you.

So, one proposed scope for the Commission's review is that since you're primarily interested in Veterans, we really should be looking at all adults over the age of

18.

So the research we'll be gathering are -- will exclude children. But include all adult patients.

Now one of the options you have is to say, well no, I only want to see military and Veteran studies. I would recommend that you not do that.

Because I think the literature is relatively small. And I think in this case, the literature on any adult will inform your evidence-based decisions about the effectiveness of the potential interventions.

I'd also suggest that your charge says that you're to concentrate on mental health conditions. And to look at VA's evidence-based treatment models, and how they might be incorporated into those models.

So the conditions that I think are highest priority for you are post-traumatic stress disorder, major depressive disorder, substance use disorder, including alcohol and

opioid use disorder, and suicidal behaviors.

There was some discussion yesterday about pain and stress as interest of the Commission. And I think that one of the slides that was shown on the clinical practice guidelines was the opioid therapy for chronic pain guidelines.

And the way the guidelines usually handle issues of associated conditions, or comorbidities, is that we'll focus on the primary condition.

And then within the guideline there may be a warm handoff to say, some of the guidelines related to pain is in this guideline and the recommendations reside there.

I believe it's outside of your charge to do a primary study of pain. But that's obviously a matter of discussion for this group.

At this point I'd like to stop and maybe get your feedback on this proposed scope. And some of your thoughts about what your

priorities are and how we can organize the work going forward.

Is that okay Mr. Chairman?

CHAIR LEINENKUGEL: Fran, that's perfect. And I think it's an opportunity for us to ask a couple of questions of Fran.

Because we are talking scope here. We are talking a compressed amount of time in that 18 months like we started the meeting off with.

So please, interject at this point. I think it's critical that all of us have a point of view.

DR. MURPHY: So, and if I could, I'll just add that one of the things I should have said when I brought up the time line slide is that the more conditions we include, the more key questions there are, the longer time it takes to actually gather and review that literature.

So, if we enlarge the scope, we're likely not to meet your 18-month time line.

CHAIR LEINENKUGEL: Yeah. You and I had this side discussion at the end of yesterday. So, I'll start.

And there was the question about pain. And I am a true believer, again, as a lay person, but just from my 18 months of experience in dealing with Veterans throughout the country, that there is a direct correlation with pain, opioid abuse, and potential suicide.

So that's where I'm at. I mean, we're going to be looking at opioid use disorder. Me not being a doctor, is smart enough to realize that if you're on opioids, you obviously have some pain.

So, if it's a disorder, I just put my lay person mind onto the subject saying that pain must be very much involved in this directly or indirectly.

My point of view only.

DR. BEEMAN: Jake, I'm not going to disagree with you because I'm not a clinician. On the other hand, I want to agree with Dr.

Murphy on this one.

I think that there's a cause and effect. You know, I think that you take opioids because you have the pain.

I mean, there's a lot of pain and stress in the overall environment. And I think if we studied all of it, we would be here the rest of our lives.

I like the compactness of this. Understanding that, you know, knowing about pain and knowing what are the precipitating factors, why people get suicidal ideation and everything, is a result of some of these other factors.

Where -- because I don't -- and I could be wrong, I don't look at alcohol use as exactly the same as pain. I look at alcohol use as a result of pain and stress.

CHAIR LEINENKUGEL: My point exactly. I concur.

DR. BEEMAN: Okay.

DR. MAGUEN: You know, one of the

things that I think has been the elephant in the room is just the tremendous comorbidity that exists. That we see on the ground.

And so, I think that, you know, for me some of these complementary and integrative treatments, so for example if someone comes to me and they have PTSD and they also have chronic pain and substance use disorder, I think that all of those things we need to look at together in order to develop the best treatment plan.

And so just jumping ahead for example, even if we're evaluating acupuncture for this person. So the evidence for pain and acupuncture is a lot stronger than for PTSD. Which is insufficient evidence as we've just heard.

And so, it's -- unless we look at the whole clinical picture, sometimes it's very hard to make those determinations.

And so, I'll just -- I don't have a definitive thought about yes or no yet. But I

think -- I just want to put that out there.

That it's often times, the rates of comorbidity are so high that even if we're not looking at it, we're looking at it indirectly.

DR. JONAS: I want to concur with that. I see patients with chronic pain every week.

And the only reason they might not have a comorbidity is because I haven't asked them. Okay.

At least in my population. And in those areas. And I think very often, people with things that we're dealing with in mental health will come in with pain as the primary complaint.

Especially in primary care. And then we'll go down the path of treating that pain without actually getting at the underlying issues.

And then that creates problems. It even causes harm. I guess my question would be, is it redundant?

Hasn't this already been done? And if it's already been done, then why would we repeat it?

On the other hand, if it's already been done, we can just build on that. So it shouldn't require a whole lot more work.

So, that would be a couple -- and.

DR. MURPHY: So maybe, and I haven't practiced clinical neurology for a long time. But I used to run a headache clinic.

And a lot of my clinical practice was in the borderlands between, you know, neurology pain and mental health.

And I would just say that even though you may have a patient who has a significant pain problem, if the primary diagnosis is one of the four or five conditions listed on the slide, you structure the treatment plan so that you're addressing both the primary and secondary diagnosis.

But the treatments are different. And your tasking is to determine whether the

complementary and integrative health treatments are effective in improving the mental health outcomes.

That doesn't mean that we can't look at what has been done by VA in the state of the art conference and other information that's been gathered by OP -- by the Office of Patient Centered Care, and incorporate, you know, this holistic model.

In fact, I would recommend that you do that. But, that work is, you know, related but preferable to your charge.

DR. JONAS: So, I'd say we need -- we don't have to repeat that work. But I think we need to make it a core part of what's presented.

Because we're going to have to take that into context. So, at least, I mean, if there are major updates that are required, then that's different.

But if we at least see what that information is as part of what's presented as

you go into these areas.

I will can -- I will make a prediction that you'll go through the entire review for these conditions for complementary and integrative medicine practices, individual practices.

And by the way, we're also asked to talk about models. Even more difficult.

And we will end up in the insufficient evidence for everything in those areas. That's probably what will happen.

So we need to go beyond that to really do the acceleration that Jake and others described about in an earlier conference.

DR. MURPHY: And if the Commission wants to deliberate on the issue of pain further, what I can suggest is that if you could give us your decision that at least for mental health conditions, these are the issues that you'd like us to cover, we can begin this portion of the evidence review once we get the key questions set.

And we can always add other issues later after you've had a chance to look at the information gathered on pain by other parts of the VA organization.

CHAIR LEINENKUGEL: Fran, I think you're headed right where we need to be going. And number one, thanks for teeing up this slide.

Because this does define the scope. And I think that it hits everything that Tom, you agreed when you first saw this, right?

And the rest of the Commissioners as well, I think, are pretty good with that at this point.

To what Wayne just said, there should be some sort of studies and correlation. Especially out of opioids that you should be able to provide us by next month's meeting.

And I would say try it. You're going to have a lot more support from this Administration and from this Acting Secretary then before, Fran.

So, there will be a sense of urgency behind this.

DR. MURPHY: Okay. Back up --

CHAIR LEINENKUGEL: Fran, if you could, talk more into the microphone a little bit. Thank you.

DR. MURPHY: I'm not red. I was off.

(Laughter.)

DR. MURPHY: So, this is the legislatively mandated group of what they're calling complementary and integrative health interventions.

I will tell you that some of these things are really not usually considered in that bucket of integrative health or complementary therapies.

And I'll just point out things like the HBOT, hyperbaric oxygen therapy, and trans cran -- transcranial magnetic stimulation. Those are a little bit, you know, different then some of the other integrative health

treatments.

And I wonder what your thoughts are? We'll cover all of these. But it also says other therapies that the Commission determines are appropriate for study.

Were there other issues that were of particular interest to you? Under yoga, we cover yoga and tai chi.

Under meditation, would be meditation and mindfulness and other forms of meditation. But other things that are not on that list that are of very high priority for you?

DR. BEEMAN: I had talked to Jake about putting this on the record. So, I just want to just mention something.

I think family therapy, which I know is an accepted therapy. But is also part of a holistic treatment system, should be part of this.

And I would just make a comment. Nine years ago when the National Intrepid

Center of Excellence was put into place by the DoD, the Fisher Family donated 65 million dollars, or raised 65 million dollars to help the government get this started.

For the past nine years, they've been accepting about one or two patients a day. So typically they have about 30 patients at any one time, in what is really basically a 30-day intensive outpatient program.

Almost all of these therapies, with the exception of equine and HBOT, is -- are used there. And so they have nine years worth of data.

It's populated by neurologists, internists, psychiatrists, podiatrists, radiologists, they have chaplains and a whole host of other folks.

And in addition to that too, they do virtual reality. Where they have experts that can recreate the events.

I'm not sure nine years into it what the data's suggesting. But they might make --

might have some very helpful information for your research into this for us.

To say, yeah, you know what, we've been using this for nine years. This is what we're finding. These are the results.

I can say that the patients they took were mild to moderate. They did not take the really intractable kinds of patients.

And they've had both men and women in the thing. So, maybe something to look at if you haven't done that already.

But, I just wanted to put a word in for the family therapy piece. Because I think all of these treatments are enhanced by the ability to have the shared experience within the context of family.

Thank you.

CHAIR LEINENKUGEL: Well, I'll make my pitch one more time. Yes, medical cannabis, synthetic cannabinoids needs to be included.

And will be included, at least from the Chairman's perspective. But I think Shira

also agreed with me.

That there's been some things going on. Even within the VA or with some VA doctors.

There are large groups of Veterans across America right now, one group that I will bring in, the Veterans Cannabis Project Group, with five Veteran heroes.

They're people that went and served multiple times. And came back and got their doctorates from either Harvard or Yale.

I mean, they're -- you would not expect them to be looking at cannabinoids. But they're very much involved. That being one.

Hyperbaric oxygen treatment. There are two large groups that have pinged to me for the past 12 to 13 months. They're becoming much more proactive.

They're gaining resonance on the Hill and also in states. So, whether or not we think that treatment works or has any evidence based to it at this point in time, it is not

relevant to me.

I think it needs to be explored, because I did listen to Veterans that have gone through different pressure treatments over various periods of times at different depth levels, per se, which is pressure.

That absolutely swear by it. Got off all of their opioids. Have less pain. Clearer thinking, et cetera.

So, it's all anecdotal. But at least it's something that's up there. And it's been put up there for a reason when this law was written two years ago.

DR. JONAS: Yeah. I'd like some time to look over this list. Instead of sealing it down right here.

I think the big risk, number one, is that we get into the this for that. Everything becomes therapy, a component.

And you go down the laundry list like this. And our first charge is actually looking at models of care.

And this won't allow us to look at models of care if we're simply looking at the components.

I think you're getting at it with family therapy. I mean, that's a system, a model of care.

We've seen several models of care already yesterday. A lot of them were described.

The one, I think, that has the greatest interest is this whole person, integrative health model. Which is a very different way of delivering the same kind of care that incorporates some of these and some of the conventional stuff.

That's why it's called integrative. And so we should look at those models of care and what evidence do we have for that.

Or gaps. What gaps are in those areas? So, I think we -- that would be number one in my opinion. Instead of just adding to this list.

With that said, I would add to the list. And I agree with you completely that cannabis, medical cannabis needs to be up there.

I think hyperbaric oxygen needs to be looked at because of the issues that have emerged since the last reviews.

I think spiritual care is a key issue. And there's various forms of doing that. Especially for PTSD.

There's retreats for example. Some of which have been studied and shown profound changes that occur through a therapeutic treating group.

Many of those are run by chaplains outside. So, spiritual care is a key component.

I think that -- I don't know if you pulled off the transcranial electromagnetic stuff. But there's a wider category, it's called CES, cranial electrical stimulation.

There was a review in the Annals

just a few months ago about that. And I think that ought to be on there.

Transcranial is a subset of that. But there are FDA, I don't know if they're approved or not, but you can certainly buy them online.

And the FDA has at least partly blessed things like Fisher devices and things like that. That, you know, for depression, for insomnia, for, you know, things like that.

So I think those ought to be looked at. If you talk to the nurses, they will describe, and the Hague Report had this on VA use, of things like therapeutic touch, healing touch for example.

It's a bioenergy type of practice that nurses deliver. And there are certifications for it.

There's been some randomized control trials on that. And we should look at that. And then osteopathic aspect.

I know chiropractic is considered